DEPARTMENT OF HEALTH AND HUMAN SERVICES

MAINECARE HOME HEALTH ADMIT/DISCHARGE FORM (AGE 21 AND OLDER)

Member: ______________________________________ **Provider Name:** _____________________________

MaineCare Number: ☐☐☐☐☐☐☐☐☐ **Provider Telephone:** _________________________

Provider Contact Person: ________________________ **Provider Fax:** __________________________

♦♦

☐ **NEW ADMIT TO YOUR AGENCY (send only to OES Fax # 287-9231)** **Original Start of Care Date:** ___/___/___

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☐ **Psychiatric Medication Services ONLY:** Member has a severe and disabling mental illness that meets the eligibility requirement set forth in Section 17. The only service covered is medication administration or monitoring.

(ANY ADDITIONAL HOME HEALTH SERVICES REQUIRE PRIOR AUTHORIZATION UNDER THIS EXEMPTION)

RN Start of Care: ___/___/___

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Check appropriate Box: ☐ **1st Certification Period** ☐ **2nd Certification Period**

☐ **Readmit within Cert Period (after hospitalization/NF stay – include new HCFA485)** **1.** ☐ **2.**☐ **3.**☐

NURSING SERVICES:	**Start of Care**	
☐ * RN - Teach and Train	____/____/____	**PA REQUIRED AFTER THE FIRST 120 DAYS FOR ALL CATEGORIES OF SERVICE IN THIS SECTION, EXCLUDING PSYCHIATRIC MEDICATION SERVICES – SEE ABOVE**
☐ * RN Assessment Management ♦	____/____/____	* **Limited to 120 days per admission**
☐ RN - Skilled Nursing	____/____/____	♦ For new/recent medical condition w/in past 30 days
☐ Psychiatric Medication Services (when receiving additional services)	____/____/____	
☐ Home Health Aide	____/____/____	
☐ MSW (not allowed as stand alone – must also have RN, PT, OT or ST)	____/____/____	

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THERAPIES:	Once rehabilitation potential has been established for members aged twenty-one (21) or older, they are specifically eligible only for physical and occupational therapy in the following circumstances (check one):
☐ **Rehab Potential Documented**	☐ treatment following an acute hospital stay for a condition affecting range of motion, muscle strength and physical functional abilities.
☐ Physical Therapy Start of Care ____/____/____	☐ treatment after a surgical procedure performed for the purpose of improving physical function.
☐ Occupational Therapy Start of Care ____/____/____ ☐ Speech Therapy Start of Care____/____/____	☐ treatment in those situations in which a physician has documented that the member has, in the preceding thirty (30) days, required extensive assistance (defined in Section 40.01-6) with at least one person physical assist (defined in Section 40.01-16) in the performance of one (1) or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility;

DISCHARGED TO (SEND ONLY TO OES FAX # 287-9231)	**HOME HEALTH END DATE**
☐ Long-term Care Program (name) ________________________________	Date ___________
☐ Home, Medicare/3rd party payer service	Date ___________
☐ Home, no service	Date ___________
☐ Hospital	Date ___________
☐ Residential Care (name) ____________________________	Date ___________
☐ Nursing Facility (name) ____________________________	Date ___________
☐ Death	Date ___________
Person completing this form: _______________________________________	**Date** ___________